ARC 3093C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 217.6, the Department of Human Services hereby amends Chapter 7, "Appeals and Hearings," Iowa Administrative Code.

On April 1, 2016, the Department of Human Services transitioned most Iowa Medicaid members to a managed care program called Iowa Health Link. This program is administered by three contracted Managed Care Organizations (MCOs) that provide members with comprehensive health care services, including physical, behavioral and long-term care services and support. These adopted amendments to Chapter 7 clarify that appeals related to health care decisions made by an MCO must follow a different process than the one used for other Department appeals. A member, the member's representative, or a provider acting on the member's behalf with the member's written consent may file an appeal; however, the appellant must exhaust the first-level review process with the MCO prior to appealing to the Department. Providers cannot file an appeal on their own behalf or relating to a claims dispute issue with an MCO. The managed care contract does not allow appeal hearings to be granted for either instance.

Currently, individuals who are appealing a food assistance, Medicaid, or Healthy and Well Kids in Iowa action may appeal verbally. All other individuals must appeal in writing. These amendments allow individuals who are appealing a child care assistance or Family Investment Program action to also be able to file an appeal verbally. This change expands the programs that can accept verbal appeals.

Individuals who appeal an action taken regarding the Autism Support Program currently have 30 calendar days to file an appeal. These amendments extend the time frame to file an appeal related to this program to 90 calendar days to provide appellants better access to the appeals process.

Whenever the Department proposes to cancel or reduce assistance or services or to revoke a license, certification, approval, registration, or accreditation, it must give timely and adequate notice. These amendments remove the requirement that the Employees' Manual chapter number and subheading be included on a Department notice to make it an adequate notice.

Assistance shall not be reduced, restricted, discontinued, or terminated, nor shall a license or registration be revoked, or other proposed adverse action be taken pending a final decision on an appeal when certain criteria are met. As the criteria for food assistance decisions and MCO decisions are different, the rule regarding continuation of benefits while an appeal is pending is revised. The amendments provide general standards for when benefits will or will not continue and include new provisions that set forth the specific criteria for food assistance decisions and MCO decisions.

If an appellant indicates that the appellant's life, health or ability to attain, maintain or regain maximum function could seriously be jeopardized if the appellant has to wait for a standard resolution of an appeal, the appellant can request an expedited appeal hearing, which must be held within three working days of the date on the appeal request. These amendments include the criteria that must be met in order to receive an expedited appeal hearing regarding a health care decision made by the MCO.

When an appeal hearing is scheduled and the appellant or Department's representative is unable to attend, the appellant or Department's representative may request a continuance. These amendments clarify that food assistance appeals and intentional program violation appeals can be rescheduled but add restrictions as to how long an appeal may be postponed.

When the Department fails to appear for an appeal hearing and files a motion to vacate a default decision, the Department will now be required to follow the same process it follows when filing a review request. The motion to vacate will need to be presented to the Appeals Advisory Committee.

If an appellant fails to appear for an appeal hearing and files a motion to vacate a default decision, the appeal is returned to the administrative law judge to rule on the appellant's motion to vacate. If the motion is granted, the judge orders that a new appeal hearing be scheduled. However, the current rules require that a final decision be issued before the new appeal hearing can be scheduled. This requirement is confusing for appellants and Department staff. Typically, when the final decision is issued, this means

the appeal is closed. These amendments remove the requirement that a final decision be issued after a motion to vacate is granted. Instead, the appeal record will be held to allow all parties an opportunity to request a review if they disagreed with the granting of the motion to vacate, but instead of issuance of a final decision after the review time frame is exhausted, the file will be returned to the Department of Inspections and Appeals to schedule an appeal hearing.

Other amendments are made to remove outdated references, update form names and numbers, and provide further clarification where necessary.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 2972C** on March 15, 2017. The Department received comments from two respondents during the public comment period. The respondents' comments and the Department's responses to those comments are as follows:

Comment 1: One respondent argued that the proposed change regarding witnesses being allowed to appear by teleconference if they request to do so is in conflict with Iowa Code section 17A.13. The respondent stated that witnesses are permitted to appear by telephone, in most hearings, but there may be times when the demeanor of a witness or another issue may be so critical that in-person testimony is necessary.

Another respondent requested that the proposed change be expanded to allow a party to request that a witness appear by teleconference. The respondent also requested the addition of language stating that, if a witness has been subpoenaed to appear in person and good cause is shown, the witness may be required to appear in person.

Department response 1: The Department agrees with the second respondent's proposed changes and has amended subrule 7.10(5) to read as follows:

"**7.10(5)** *Method of hearing.* The department of inspections and appeals shall determine whether the appeal hearing is to be conducted in person, by videoconference or by teleconference call. The parties to the appeal may participate from multiple sites for videoconference or teleconference hearings. Any appellant is entitled to an in-person hearing if the appellant requests one. Upon advance request, a witness shall be permitted to appear by teleconference unless the administrative law judge determines that the physical presence of the witness is necessary for the administration of justice and does not impose an undue burden on the witness. All parties shall be granted the same rights during a teleconference hearing as specified in rule 441—7.13(17A). The appellant may request to have a presiding officer render a decision for attribution appeals through an administrative hearing."

Comment 2: One respondent stated there was no reason provided as to why continuances on food assistance and intentional program violation cases would be limited to 30 days. The respondent requested that the proposed language be removed as there are situations when a longer continuance would be justified.

In addition, one respondent commented that the change limiting the number of continuance requests on intentional program violation cases is ambiguous and confusing. The respondent agreed with the change but requested minor revisions for clarification purposes.

Department response 2: Federal regulations at 7 CFR 273.15(c)(4) limit continuances on food assistance cases and postponements shall not exceed 30 days. Federal regulations at 7 CFR 273.16(e)(2)(iv) limit continuances on intentional program violation cases. The hearing cannot be postponed for more than a total of 30 days. While the regulations are not new, references were added to the Department's rules for clarification purposes.

However, based on the comments received, new paragraph 7.10(6)"c" has been revised to read as follows:

"*c.* For intentional program violation appeals, the hearing may be rescheduled provided that the request for postponement is made at least ten days in advance of the date of the scheduled hearing. The hearing shall not be postponed for more than a total of 30 days."

Comment 3: One respondent questioned the proposed change to subrule 7.24(1) to define which agency may issue a written order to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the Department of Human Services' jurisdiction by emergency adjudicative order. The respondent did not have concerns with the

amendment but questioned the intent of the change and whether there will be an anticipated increase in the use of the procedure.

Department response 3: The Department does not anticipate an increase in the use of this procedure. While no amendments were proposed to the existing definitions of "agency," "department," or "department of inspections and appeals" in rule 441—7.1(17A), subrule 7.24(1) was revised because the terminology used within the rule was used interchangeably to mean either the Department of Human Services or the Department of Inspections and Appeals. The amendment clarifies which department is responsible for the actions stated. No change was made to subrule 7.24(1) as the result of comments from the respondent.

Comment 4: One respondent commented on subrule 7.2(5), which states that a member or authorized representative or provider who acts on behalf of a member can get a state fair hearing if that person has exhausted the first-level review process through a managed care organization and remains dissatisfied with the outcome. The respondent suggested additional language be added stating, "if the managed care organization fails to adhere to notice and timing requirements, then it may be deemed that the member, their authorized representative or provider when acting on behalf of a member has exhausted the managed care organizations appeals process and may initiate a state fair hearing."

Department response 4: The Department has revised subrule 7.2(5) by adding a new paragraph "c," which reads as follows:

"*c.* If the managed care organization fails to adhere to the notice and timing requirements in 42 CFR 438.408, the Medicaid member, authorized representative or provider who is acting on behalf of the member is deemed to have exhausted the managed care organization's appeals process. The Medicaid member, authorized representative or provider who is acting on behalf of the member may initiate a state fair hearing."

Comment 5: One respondent commented on subrule 7.5(1), which states that a hearing shall be granted to any appellant when the right to a hearing is granted by state or federal law. The respondent argues that the proposed change in the Notice of Intended Action removes the right to a hearing as granted by the Constitution.

Department response 5: Whether or not the word "Constitution" is present in the rule, the Constitution still applies to any action taken by a state agency, and therefore, any constitutional requirement for a hearing would still be present. The Department did not remove the amendment to subrule 7.5(1) based on the respondent's comment.

Comment 6: One respondent commented on subrule 7.5(2) regarding when a hearing is not granted. A hearing cannot be granted when the appellant has not exhausted the first-level review process with a managed care organization. The respondent suggested additional language that would allow a hearing to be granted when it is deemed the appeals process with the managed care organization has been exhausted, even if the appellant has not exhausted the first-level review process.

Department response 6: The Department agrees with the respondent and has revised subparagraph 7.5(2)"d"(3) to read as follows:

"(3) The appellant has not exhausted the first-level review process with a managed care organization except as provided at paragraph 7.2(5)*'c.'*"

Comment 7: One respondent commented that the term "medical assistance" referenced in subrule 7.5(4) and rule 441—7.8(17A) is not defined in rule 441—7.1(17A). The proposed amendments to subrule 7.5(4) regarding the time limit for granting a hearing to an appeal remove references to "Medicaid or healthy and well kids in Iowa" and replaced them with a reference to "medical assistance." The commenter requested that the Department either define the term "medical assistance" in rule 441—7.1(17A) or restore the reference to the Healthy and Well Kids in Iowa Program in subrule 7.5(4).

The respondent also requested that additional language be added to paragraph 7.5(4)"b" to clarify that a hearing will be held if an appeal is made within 90 days after the appeal is deemed to be exhausted.

Department response 7: While the term "medical assistance" is not defined in rule 441—7.1(17A), it is believed the definition utilized in subrule 7.2(3) addresses the respondent's concern. Subrule 7.2(3) provides a list of Medicaid coverage groups or programs that are considered in the term "medical

assistance." Healthy and Well Kids in Iowa is one of the items included in this list. Based on the comment received, paragraph 7.5(4)"b" has been revised to read as follows:

"*b. Food assistance, medical assistance or autism support program standard.* For appeals regarding food assistance, medical assistance or the autism support program, a hearing shall be held if the appeal is made within 90 days after official notification of an action. For appeals regarding a health care decision made by a managed care organization, a hearing shall be held if the appeal is made within 90 days after written notification that the first-level review process through the managed care organization has been exhausted. A hearing shall be held if the appeal is made within 90 days after the appeal is deemed to have exhausted the managed care organization's appeals process, as provided in paragraph 7.2(5) *'c.'*"

Comment 8: One respondent objected to the proposed change to subparagraph 7.7(1)"e"(3). The change removes the requirement that Department notices contain the manual chapter number and subheading that support the action. The respondent requested that the Department rescind this change and leave the requirement that manual information be included on notices.

Department response 8: Federal regulations at 42 CFR 431.210 and 7 CFR 273.13 dictate the information that must be provided on a notice of adverse action. Regulations require that the Department only provide references to the regulations that support the action that was taken. There are no federal requirements directing the Department to provide manual references on notices. Also, the Employees' Manual has not been adopted as a formal agency rule, so it does not have the force and effect of law. The manual cannot serve as the legal basis for the Department's position. The Department did not change the amendment to subparagraph 7.7(1)"e"(4) as requested.

Comment 9: One respondent commented on proposed new subrule 7.9(3) regarding continuation of benefits for the Food Assistance Program. The respondent is concerned specifically with paragraph "e," which indicates that food assistance benefits that were time-limited through a certification period would not continue for food assistance. The respondent requested that this change be removed to allow food assistance benefits to continue pending an appeal, even when the benefits or services were time-limited. The respondent requested that if this change is based on a federal or state law, a reference to such law be included.

The respondent is also concerned with the language about "previously authorized course of treatment," "ordered by an authorized provider," and "original period covered by the original authorization" in new subrules 7.9(5) and 7.9(6). The respondent argues that it is unclear what types of situations would be covered by the subrules and believes that these changes violate state and federal regulations.

Finally, the respondent argues that new grounds for discontinuation of services have been added in subparagraph 7.9(5)"b"(3) and are inconsistent with federal regulations.

Department response 9: This change is not based on a recent federal or state law change. This requirement is part of the Department's current rules at paragraph 7.9(2)"b" and is supported by federal regulations at 7 CFR 273.15(k)(1).

The Department agrees with the respondent that notice must be given when benefits or services are terminated, suspended or reduced and that a member, the member's authorized representative or provider who has obtained written consent from the member has the right to appeal an adverse benefit determination by a managed care organization. However, federal regulations at 42 CFR 438.420 indicate when benefits can continue while the first-level review and state fair hearing appeals are pending. If an individual is receiving Medicaid waiver services and the managed care organization decides at an annual review to reduce the number of hours or minutes or units of service the individual can receive per week or month, the proposed language in new subrules 7.9(5) and 7.9(6) indicates that benefits or services would not continue as the period covered by the original authorization has expired. The individual can appeal the denial, but the individual's services may not be continued pending the outcome of the appeals process. In order for benefits or services to continue, all requirements must be met.

The Department did not adopt the language proposed in subparagraph (3) of paragraph 7.9(5)"b" of the Notice and has renumbered subparagraph (4) as (3). Paragraph 7.9(5)"b" now reads as follows:

"*b.* If, at the appellant's request, the managed care organization continues or reinstates the member's health care services while the appeal is pending, the benefits must continue until one of the following occurs:

"(1) The appellant withdraws the appeal.

"(2) The appellant fails to request an appeal within ten calendar days from the date the managed care organization mails the notice of action.

"(3) A hearing decision is issued that is adverse to the appellant."

Comment 10: The respondent suggested changes to new paragraph 7.10(4)"f" regarding expedited hearings. The respondent is concerned that the language in paragraph "f" would limit an appellant's ability to have an expedited appeal hearing to situations when the managed care organization had handled the first-level review expeditiously. The respondent argues that there may be times when an MCO does not handle a first-level review expeditiously, but the appellant's life, physical or mental health, or ability to attain, maintain or regain maximum function could seriously be jeopardized if the appellant waits for standard resolution of the appeal.

Department response 10: The Department's Appeals Section does not have a medical professional on staff and does not have someone that the Section can readily access to review medical necessity in emergency situations. All of the managed care organizations have medical professionals on staff who can evaluate and determine whether someone's life, physical or mental health or ability to attain, maintain or regain maximum function could seriously be jeopardized if that person waits for the standard resolution of the appeal.

It is expected that if the person's situation is an emergent one, the MCO would handle the first-level review expeditiously. If the MCO handles the first-level review as an expedited request, then the state fair hearing would also be held expeditiously, if the Medicaid member meets the requirements in paragraph 7.10(4)"f."

The respondent's comment will be considered in a future rules revision as the Centers for Medicaid and Medicare Services have proposed additional regulations regarding expedited appeal hearings. If those proposed regulations become final, Chapter 7 will be revisited and all references to expedited hearings will be reviewed at that time.

Comment 11: The respondent requested that the Department reinstate language about notifying appellants by certified mail, return receipt requested, in paragraph 7.10(7)"c" as intentional program violations carry serious consequences.

Department response 11: The Department agrees that intentional program violations carry serious consequences. The Department previously notified individuals that they had been referred for an intentional program violation using both first-class mail and certified mail, return receipt requested. However, during a recent integrity review, the Department was instructed by the Food and Nutrition Services (FNS) to mail Notices of Hearing by either first-class mail or certified mail, return receipt requested, as allowed by 7 CFR 273.16(e)(3)(i). The Department did not revise the proposed amendment to paragraph 7.10(7)"c" as requested.

The Council on Human Services adopted these amendments on May 10, 2017.

These amendments do not provide for waivers in specified situations because requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 217.6.

These amendments will become effective July 12, 2017.

The following amendments are adopted.

ITEM 1. Rescind the definition of "Aggrieved person" in rule **441—7.1(17A)** and adopt the following **new** definition in lieu thereof:

"Aggrieved person" means a person against whom the department has taken an adverse action. This includes a person who meets any of the conditions in rule 441—7.2(17A).

ITEM 2. Amend rule **441—7.1(17A)**, definitions of "Bidder" and "Reconsideration," as follows:

"Bidder" means an individual or entity that submits a proposal in response to a competitive procurement issued by the department of human services.

"Reconsideration" means a review process that must be exhausted before an appeal hearing is granted. Such review processes include, but are not limited to, a reconsideration request through:

1. The Iowa Medicaid enterprise (IME) ~~or its subcontractors~~,

~~2. The managed health care review committee,~~

~~3.~~ 2. A division or bureau within the department,

~~4.~~ 3. The mental health and disability services commission,

~~5.~~ 4. A licensed health care professional as specified in 441—paragraph 9.9(1)*"i,"* or

~~6.~~ 5. Any division or bureau within the department, from a bidder in a competitive procurement bid process.

Once the reconsideration process is complete, a notice of decision or notice of action will be issued with appeal rights.

ITEM 3. Adopt the following **new** definitions of "First-level review," "FMAP-related," "'Managed care organization' or 'MCO'" and "SSI-related" in rule **441—7.1(17A)**:

"First-level review" means a review process that must be exhausted through a managed care organization before an appeal hearing is granted. Once the first-level review process is complete, a notice of decision will be issued by the managed care organization and will identify further appeal rights, if applicable.

"FMAP-related" describes coverage groups whose eligibility criteria are derived in relation to the family medical assistance program, directed toward children and their parents or caretakers.

"Managed care organization" or *"MCO"* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" in Iowa Code section 514B.1.

"SSI-related" describes medical assistance coverage groups whose eligibility criteria, except for income and resource limits, are derived from the supplemental security income (SSI) program for people who are aged, blind, or disabled.

ITEM 4. Adopt the following **new** rule 441—7.2(17A):

441—7.2(17A) Conditions of an aggrieved person. To be eligible for an appeal hearing, a person must meet the definition of "aggrieved person" in rule 441—7.1(17A) and qualify on a program-specific basis.

7.2(1) *Financial assistance.* Financial assistance includes, but is not limited to, the family investment program; refugee cash assistance; child care assistance; emergency or disaster assistance; family or community self-sufficiency grants; family investment program hardship exemptions; and state supplementary assistance dependent person, in-home health-related care, and residential care facility benefits. Issues may include:

a. A request to be given an application was denied.

b. An application for assistance has been denied or has not been acted on in a timely manner.

c. The effective date of assistance is contested.

d. The amount of benefits granted is contested.

e. The assistance will be reduced or canceled.

f. An overpayment of benefits has been established, and repayment is requested.

7.2(2) *Food assistance.* Issues may include:

a. A request to be given an application was denied.

b. An application for assistance has been denied or has not been acted on in a timely manner.

c. The effective date of assistance is contested.

d. The amount of benefits granted is contested.

e. The assistance will be reduced or canceled.

f. A request to receive a credit for benefits from an electronic benefit transfer (EBT) account has been denied.

g. An overpayment of benefits has been established, and repayment is requested.

7.2(3) *Medical assistance eligibility.* Medical assistance eligibility includes, but is not limited to, FMAP-related coverage groups, SSI-related coverage groups, the breast and cervical cancer treatment program, the health insurance premium payment program, healthy and well kids in Iowa (HAWK-I), the Iowa Health and Wellness Plan, family planning services, and waiver services. Issues may include:

a. A request to be given an application was denied.

b. An application has been denied or has not been acted on in a timely manner.

c. The person's eligibility has been terminated, suspended or reduced.

d. The level of benefits the person is eligible to receive has been reduced.

e. A determination of the amount of medical expenses that must be incurred to establish income eligibility for the medically needy program or a determination of income for the purposes of imposing any premiums, enrollment fees or cost sharing is contested.

f. The level of care requirements have not been met.

g. The failure to take into account the appellant's choice in assignment to a coverage group.

h. The effective date of assistance is contested.

i. The amount or effective date of one of the following is contested:

(1) Health insurance premiums,

(2) Healthy and well kids in Iowa premiums,

(3) Medicaid for employed people with disabilities premiums,

(4) Iowa Health and Wellness Plan contributions,

(5) Client participation, or

(6) Medically needy program spenddown.

j. An overpayment of benefits has been established, and repayment is requested.

7.2(4) *Fee-for-service medical coverage.* Issues may include:

a. The level of services that the person is eligible to receive has been reduced.

b. The level of services provided by a nursing facility is not needed based on a preadmission screening and resident review (PASRR) evaluation.

c. The effective date of services is contested.

d. A claim for payment or prior authorization has been denied.

e. The medical assistance hotline has issued notification that services not received or services for which an individual is billed are not payable by medical assistance.

f. Nonemergency medical transportation services by the broker designated by the department pursuant to rule 441—78.13(249A) have been denied.

7.2(5) *Managed care organization medical coverage.*

a. A Medicaid member, an authorized representative or a provider who is acting on behalf of a member has been notified that the first-level review process through a managed care organization has been exhausted and remains dissatisfied with the outcome.

b. If a provider is acting on behalf of a member by filing this type of appeal, the member's written consent to appeal must be submitted with the appeal request.

c. If the managed care organization fails to adhere to the notice and timing requirements in 42 CFR 438.408, the Medicaid member, authorized representative or provider who is acting on behalf of the member is deemed to have exhausted the managed care organization's appeals process. The Medicaid member, authorized representative or provider who is acting on behalf of the member may initiate a state fair hearing.

7.2(6) *Providers.* Providers can be an individual or an entity. Issues may include:

a. A license, certification, registration, approval or accreditation has been denied or revoked or has not been acted on in a timely manner.

b. A fee-for-service claim for payment or request for prior authorization of payment has been denied in whole or in part and the provider states that the denial was not made according to department policy.

c. A medical assistance patient manager contract has been terminated.

d. A payment has been withheld to recover a prior overpayment, or an order to repay an overpayment pursuant to 441—subrule 79.4(7) has been received.

e. An application for child care quality rating has not been acted upon in a timely fashion.

f. A child care quality rating decision is contested.

g. A certificate of child care quality rating has been revoked.

h. An adverse action has been taken relating to the Iowa electronic health record incentive program pursuant to rule 441—79.16(249A), including:

(1) Provider eligibility determination,

(2) Incentive payments, or

(3) Demonstration of adopting, implementing, upgrading and meaningful use of technology.

i. An application or reapplication for licensure was issued as a provisional license.

j. A license has been issued for a limited time.

7.2(7) *Social services.* Social services include, but are not limited to, adoption, foster care, and family-centered services. Issues may include:

a. A request to be given an application was denied.

b. An application for services or payment for adoption subsidy or foster care has been denied or has not been acted on in a timely manner.

c. An application or license has been denied based on a record check evaluation.

d. A determination that a person must participate in a service program is contested.

e. A claim for payment of services has been denied.

f. A protective or vendor payment has been established.

g. The services have been reduced or canceled.

h. An overpayment of services has been established, and repayment is requested.

i. An adoptive placement of a child has been denied or delayed when an adoptive family is available outside the jurisdiction with responsibility for handling the child's case.

j. A referral to community care was not made as provided in rule 441—186.2(234).

k. A referral to community care as provided in rule 441—186.2(234) was made and the community care provider's dispute resolution process has been exhausted.

7.2(8) *Child support recovery.* Issues may include:

a. A person is not entitled to a support payment in full or in part because of the date of collection, as provided under rule 441—95.13(17A), or a dispute based on the date of collection has not been acted on in a timely manner.

b. A claim or offset is contested as provided in 441—subrule 95.6(3), 95.7(8), or 98.81(3) by a person's alleging a mistake of fact. "Mistake of fact" means a mistake in the identity of the obligor or in whether the delinquency meets the criteria for referral or submission. The issue on appeal shall be limited to a mistake of fact. Any other issue may be determined only by a court of competent jurisdiction.

c. A name has been certified for passport sanction as provided in Iowa Code section 252B.5.

d. A termination in services has occurred as provided in rule 441—95.14(252B).

7.2(9) *PROMISE JOBS.* Issues may include:

a. A claim for participation allowances has been denied, reduced, or canceled.

b. The contents of the family investment agreement are not sufficient or necessary for the family to reach self-sufficiency.

c. The results of informal grievance resolution procedures are contested, an opportunity for an informal grievance resolution has been declined, or a decision was not made within the 14-day period.

d. PROMISE JOBS services will be canceled due to imposition of a limited benefit plan.

e. An overpayment of benefits has been established, and repayment is requested.

f. Acts of discrimination are alleged on the basis of race, creed, color, sex, age, physical or mental disability, religion, national origin, or political belief.

7.2(10) *Child abuse registry, dependent adult abuse registry, or record check evaluation.* Issues may include:

a. A person is alleged responsible for child abuse.

b. A correction of dependent adult abuse information has been requested.

c. A record check evaluation restricted or denied employment in a health care facility, state institution, or other facility. "Employment" includes, but is not limited to, service as an employee, a volunteer, a provider, or a contractor. "Facility" includes, but is not limited to, county or multicounty juvenile detention homes and juvenile shelter care homes, child-placing agencies, substance abuse treatment programs, group living foster care facilities, child development homes, child care centers, state resource centers, mental health institutes, and state training schools.

d. A record check evaluation results in the restriction of participation in an educational training program.

7.2(11) *Mental health and disability services.* Issues may include:

a. An application for state payment under 441—Chapter 153, Division IV, has been denied or has not been acted upon in a timely manner.

b. Services under the state payment program have been reduced or canceled.

c. A request to be given an application was denied.

d. The person's eligibility has been terminated, suspended or reduced.

e. The level of benefits or services the person is eligible to receive has been reduced.

f. The effective date of assistance or services is contested.

g. The reconsideration process has been exhausted, and a person remains dissatisfied with the outcome.

h. The amount or effective date of cost-sharing requirements for the autism support program is contested.

i. A service authorization request for applied behavioral analysis services has been denied or reduced.

7.2(12) *HIPAA (Health Insurance Portability and Accountability Act).* A current or former applicant for or recipient of Medicaid or HAWK-I, or a person currently or previously in a department facility whose request:

a. To restrict use or disclosure of protected health information was denied.

b. To change how protected health information is provided was denied.

c. For access to protected health information was denied. When the denial is subject to reconsideration under 441—paragraph 9.9(1)*"i,"* persons denied access due to a licensed health care professional's opinion that the information would constitute a danger to that person or another person must first exhaust the reconsideration process.

d. To amend protected health information was denied.

e. For an accounting of disclosures was denied.

7.2(13) *Drug manufacturers.* A manufacturer that has received a notice of decision regarding disputed drug rebates pursuant to the dispute resolution procedures of a national drug rebate agreement or an Iowa Medicaid supplemental drug rebate agreement disagrees with the decision.

7.2(14) *Bidders that have participated in a competitive procurement bid process.* Appeals resulting from a competitive procurement bid process will be handled pursuant to Chapter 7, Division II.

7.2(15) *Other individuals or providers.* Individuals or providers that are not listed in rule 441—7.2(17A) may meet the definition of an aggrieved person if the department has taken an adverse action against that individual or provider.

ITEM 5. Amend rule 441—7.5(17A), introductory paragraph, as follows:

441—7.5(17A) The right to appeal. ~~Any person or group of persons~~ An aggrieved person who qualifies for an appeal as stated in rule 441—7.2(17A) may file an appeal ~~with the department concerning any issue~~. The ~~department~~ appeals section shall determine whether a hearing shall be granted.

ITEM 6. Amend subrule 7.5(1) as follows:

7.5(1) *When a hearing is granted.* A hearing shall be granted to any appellant when the right to a hearing is granted by state or federal law ~~or Constitution~~, except as limited in subrules 7.5(2) and 7.5(4).

ITEM 7. Amend subrule 7.5(2) as follows:

7.5(2) *When a hearing is not granted.* A hearing shall not be granted when:

a. One of the following issues is appealed:

(1) to (8) No change.

(9) A rate determination for foster group care services has been reviewed under rule 441—152.3(234).

(10) to (17) No change.

(18) An MCO provider ~~or Iowa plan contractor~~ fails to submit a document providing the member's approval of the request for appeal.

(19) and (20) No change.

(21) Notice has been issued regarding an MCO grievance request.

(22) Notice has been issued by an MCO to a provider regarding a claims dispute issue.

b. and *c.* No change.

d. The appeal is filed prematurely as:

(1) There is no adverse action by the department, ~~or~~

(2) The appellant has not exhausted the reconsideration process~~.~~, or

(3) The appellant has not exhausted the first-level review process with a managed care organization except as provided at paragraph 7.2(5)*"c."*

e. and *f.* No change.

~~*g.* The appellant is an "aggrieved party" as defined in rule 441—22.1(225C) and is eligible for a compliance hearing with the mental health and developmental disabilities commission in accordance with rule 441—22.5(225C).~~

h. and *i.* No change.

ITEM 8. Amend subrule 7.5(3) as follows:

7.5(3) *Group hearings.* The ~~department~~ appeals section may respond to a series of individual requests for hearings by requesting the department of inspections and appeals to conduct a single group hearing in cases in which the sole issue involved is one of state or federal law or policy or change in state or federal law or policy. An appellant scheduled for a group hearing may withdraw and request an individual hearing.

ITEM 9. Amend paragraph **7.5(4)"b"** as follows:

b. Food assistance, ~~Medicaid or healthy and well kids in Iowa~~ medical assistance or autism support program standard. For appeals regarding food assistance, ~~Medicaid or the healthy and well kids in Iowa program~~ medical assistance or the autism support program, a hearing shall be held if the appeal is made within 90 days after official notification of an action. For appeals regarding a health care decision made by a managed care organization, a hearing shall be held if the appeal is made within 90 days after written notification that the first-level review process through the managed care organization has been exhausted. A hearing shall be held if the appeal is made within 90 days after the appeal is deemed to have exhausted the managed care organization's appeals process, as provided in paragraph 7.2(5)*"c."*

ITEM 10. Amend paragraph **7.5(4)"c,"** introductory paragraph, as follows:

c. Offset standards. For appeals regarding state or federal tax or debtor offsets, a hearing shall be held if the appeal is made within 15 days after official notification of the action. Counties have 30 days to appeal offsets, as provided in 441~~—paragraph 14.4(1)~~*"e."* subrule 14.4(3). When the appeal is made more than 15 days but less than 90 days after notification, the director shall determine whether a hearing shall be granted.

ITEM 11. Amend paragraph **7.5(6)"a"** as follows:

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence, computation, and amount of a FIP, RCA, or PROMISE JOBS overpayment begins when the department sends the first notice informing the person of the overpayment. The notice shall be sent on:

~~1. Form 470-2616, Demand Letter for FIP/RCA Agency Error Overissuance;~~

~~2. Form 470-3490, Demand Letter for FIP/RCA Client Error Overissuance;~~

~~3. Form 470-3990, Demand Letter for PROMISE JOBS Agency Error Overissuance;~~

~~4. Form 470-3991, Demand Letter for PROMISE JOBS Client Error Overissuance; or~~

~~5. Form 470-3992, Demand Letter for PROMISE JOBS Provider Error Overissuance.~~

(1) Form 470-4683, Notice of FIP or RCA Overpayment; or

(2) Form 470-4688, Notice of PROMISE JOBS Overpayment.

ITEM 12. Amend subrule 7.5(7) as follows:

7.5(7) *Appeals of ~~Medicaid~~ medical assistance, state supplementary assistance (SSA), and HAWK-I program overpayments.*

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence and amount of a medical assistance, state supplementary assistance, or healthy and well kids in Iowa (HAWK-I) program overpayment begins when the department sends the first notice informing the person of the overpayment. The notice shall be sent on:

(1) No change.

(2) Form 470-3984, Notice of Healthy and Well Kids in Iowa (HAWK-I) Premium Overpayment.

b. No change.

c. A program overpayment means medical assistance, state supplementary assistance, or healthy and well kids in Iowa (HAWK-I) assistance was received by or on behalf of a person in excess of that allowed by law, rules or regulations for any given month or in excess of the dollar amount of assistance. Subrule 7.5(7) relates to overpayments received by recipients, not by providers of the medical assistance program.

ITEM 13. Amend subrule 7.5(9) as follows:

7.5(9) *Appeals of child care assistance benefit ~~overissuances or~~ overpayments.*

a. and *b.* No change.

c. A program overpayment means child care assistance was received by or on behalf of a person in excess of that allowed by law, rules or regulations for any given month or in excess of the dollar amount of assistance. Subrule 7.5(9) relates to overpayments received by recipients and child care providers. Either entity may be responsible for repayment.

ITEM 14. Amend paragraph **7.5(10)"a"** as follows:

a. Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence, computation, and amount of a food assistance overpayment begins when the department sends the first notice informing the person of the food assistance overpayment. The notice shall be sent on~~:~~ Form 470-4668, Notice of Food Assistance Overpayment.

~~(1) Form 470-0338, Demand Letter for Food Assistance Agency Error Overissuance;~~

~~(2) Form 470-3486, Demand Letter for Food Assistance Intentional Program Violation Overissuance; or~~

~~(3) Form 470-3487, Demand Letter for Food Assistance Inadvertent Household Error Overissuance.~~

ITEM 15. Amend subparagraph **7.7(1)"e"(4)** as follows:

(4) The ~~manual chapter number and subheading supporting the action and the~~ corresponding rule reference,

ITEM 16. Amend paragraph **7.7(2)"k"** as follows:

k. The department terminates or reduces benefits or makes changes based on a completed Form 470-2881, 470-2881(S), 470-2881(M), or ~~470-4083(MS)~~ 470-2881(MS), Review/Recertification Eligibility Document, as described at 441—~~paragraph 40.27(1)"b"~~ subrule 40.27(3) or rule 441—75.52(249A).

ITEM 17. Rescind paragraph **7.7(5)"e."**

ITEM 18. Amend rule 441—7.8(17A) as follows:

441—7.8(17A) Opportunity for hearing.

7.8(1) *Initiating an appeal.* To initiate an appeal, a person, the person's authorized representative or an individual or organization recognized by the department as acting responsibly for the person pursuant

to policy governing a particular program must state in writing that the person disagrees with a decision, action, or failure to act on the person's case.

a. ~~All appeals shall be made in writing, except for food~~ Food assistance, ~~Medicaid and healthy and well kids in Iowa~~ medical assistance, child care assistance and family investment program appeals~~, which~~ may be made in person, by telephone or in ~~person~~ writing as specified in subrule 7.8(2).

b. ~~A written request may be submitted via the department's Web site or may be delivered by mail, electronic mail, facsimile transmission or personal delivery to the appeals section, to the local office, or to the department office that took the adverse action.~~ All other appeals, subject to paragraph 7.8(1)*"a,"* shall be made in writing.

c. ~~A request by telephone or in person may be made to the appeals section or to the department office that took the adverse action.~~ A written request may be submitted via the appeals section's Web site or may be delivered by mail, electronic mail, facsimile transmission or personal delivery to the appeals section, to the local office, or to the department office that took the adverse action.

d. A request by telephone or in person may be made to the appeals section or to the department office that took the adverse action.

e. A Medicaid provider requesting a hearing on behalf of the member must have the prior express written consent of the member or the member's lawfully appointed guardian, except when appealing a medical assistance eligibility determination. No hearing will be granted unless the provider submits a document providing the member's consent to the request for a hearing.

7.8(2) *Filing the appeal.* The appellant shall be encouraged, but not required, to make written appeal on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, and the worker shall provide any instructions or assistance required in completing the form. When the appellant is unwilling to complete or sign this form, nothing in this rule shall be construed to preclude the right to perfect the appeal, as long as the appeal is in writing (except for food assistance, ~~Medicaid and healthy and well kids in Iowa~~ medical assistance, child care assistance and family investment program appeals) and has been communicated to the department by the appellant or appellant's representative.

A written appeal submitted by mail is filed on the date postmarked on the envelope sent to the department, or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency. When an appeal is submitted through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile, the appeal is filed on the date it is submitted. The electronic delivery method shall record the date and time the appeal request was submitted. If there is no date recorded by the electronic delivery method, the date of filing is the date the appeal is stamped received by the agency. Receipt date of all appeals shall be documented by the office where the appeal is received.

7.8(3) *Informal conference.* When requested by the appellant, an informal conference with a representative of the department or one of its contracted partners, including a managed care organization, shall be held as soon as possible after the appeal has been filed. An appellant's representative shall be allowed to attend and participate in the informal conference, unless precluded by federal rule or state statute.

An informal conference need not be requested for the appellant to examine the contents of the case record, including any electronic case record, as provided in subrule 7.13(1) and 441—Chapter 9.

7.8(4) *Prehearing conference.* When requested ~~by the appellant or department~~, a prehearing conference may be held with the appellant, a representative of the department and a presiding officer as soon as possible after the appeal has been filed. An appellant's representative shall be allowed to attend and participate in the prehearing conference, unless precluded by federal rule or state statute.

7.8(5) No change.

7.8(6) *Right ~~of the department~~ to deny or dismiss an appeal.* The ~~department~~ appeals section or the department of inspections and appeals has the right to deny or dismiss the appeal when:

a. It has been withdrawn by the appellant pursuant to subrule 7.8(8).

b. The sole issue is one of state or federal law requiring automatic grant adjustments for classes of recipients.

c. It has been abandoned.

d. The agency, by written notice, withdraws the action appealed and restores the appellant's status that existed before the action appealed was taken.

e. The agency implements action and issues a notice of decision or notice of action to correct an error made by the agency which resulted in the appeal.

Abandonment may be deemed to have occurred when the appellant, ~~or~~ the appellant's authorized representative, or the department fails, without good cause, to appear at the prehearing or hearing.

7.8(7) and **7.8(8)** No change.

7.8(9) *Department's responsibilities.* Unless the appeal is voluntarily withdrawn, the department worker or agent responsible for representing the department at the hearing shall:

a. Within one working day of receipt of an appeal request, ~~complete the worker information section of Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, and~~ forward ~~that form~~ Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, the written appeal, the postmarked envelope, if there is one, and a copy of the notification of the proposed adverse action to the appeals section.

b. Forward a summary and supporting documentation of the worker's or agent's factual basis for the proposed action to the appeals section within ten days of the receipt of the appeal.

c. Provide the appellant and the appellant's representative copies of all materials sent to the appeals section or the presiding officer to be considered in reaching a decision on the appeal at the same time as the materials are sent to the appeals section or the presiding officer.

ITEM 19. Amend rule 441—7.9(17A) as follows:

441—7.9(17A) Continuation of assistance pending a final decision on appeal.

7.9(1) ~~*When*~~ *General standards for when assistance continues.*

a. and *b.* No change.

c. Assistance shall be continued on the basis authorized immediately prior to the notice of adverse action, subject to paragraph 7.9(2)*"c."*

d. The appellant may ask to have the appellant's benefits continue on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing. If the form does not positively indicate that the appellant has waived continuation of benefits, the department shall assume that continuation of benefits is desired.

e. Once benefits are continued or reinstated, the department will not reduce or terminate benefits while the appeal is pending, subject to subrule 7.9(2).

7.9(2) ~~*When*~~ *General standards for when assistance does not continue.* Assistance shall be suspended, reduced, restricted, or canceled; a license, registration, certification, approval, or accreditation shall be revoked; and other proposed action shall be taken pending a final decision on appeal when:

a. to *d.* No change.

~~**7.9(3)** *Recovery of excess assistance paid pending a final decision on appeal.* Continued assistance is subject to recovery by the department if its action is affirmed, except as specified at subrule 7.9(5).~~

~~When the department action is sustained, excess assistance paid pending a hearing decision shall be recovered to the date of the decision. This recovery is not an appealable issue. However, appeals may be heard on the computation of excess assistance paid pending a hearing decision.~~

7.9(3) *When assistance continues for food assistance.*

a. Assistance, subject to paragraph 7.9(3)*"b,"* shall not be suspended, reduced, restricted, or canceled or other proposed adverse action taken pending a final decision on an appeal when the appellant requests a hearing within ten days from receipt of a notice suspending, reducing, restricting, or canceling benefits.

The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. If it is determined at a hearing that the issue involves only federal or state law or policy, assistance will be immediately discontinued.

c. Assistance shall be continued on the basis authorized immediately prior to the notice of adverse action, subject to paragraph 7.9(4)*"c."*

d. The appellant may ask to have the appellant's benefits continue on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing. If the form does not positively indicate that the appellant has waived continuation of benefits, the department shall assume that continuation of benefits is desired.

e. Once benefits are continued or reinstated, the department must not reduce or terminate benefits while the appeal is pending, subject to subrule 7.9(4).

~~**7.9(4)** *Recovery of excess assistance paid when the appellant's benefits are changed prior to a final decision.* Recovery of excess assistance paid will be made to the date of change which affects the improper payment. The recovery shall be made when the appellant's benefits are changed due to one of the following reasons:~~

~~*a.* A determination is made at the hearing that the sole issue is one of state or federal law or policy or change in state or federal law or policy and not one of incorrect grant computation, and the grant is adjusted.~~

~~*b.* A change affecting the appellant's grant occurs while the hearing decision is pending and the appellant fails to request a hearing after notice of the change.~~

7.9(4) *When assistance does not continue for food assistance.* Assistance shall be suspended, reduced, restricted, or canceled or other proposed action shall be taken pending a final decision on appeal when:

a. An appeal is not filed within ten days from the date notice is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. Benefits or services were time-limited through a certification period or for which adequate notice was provided.

c. The appellant directs the worker in writing to proceed with the intended action.

d. Adverse action was taken because the appellant failed to return a complete review form.

~~**7.9(5)** *Recovery of assistance when a new limited benefit plan is established.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new limited benefit plan period is established. A new limited benefit plan period shall be established when the department is affirmed in a timely appeal of the establishment of the limited benefit plan. All of the following conditions shall exist:~~

~~*a.* The appeal is filed either:~~

~~(1) Before the effective date of the intended action on the notice of decision or notice of action establishing the beginning date of the LBP, or~~

~~(2) Within ten days from the date on which a notice establishing the beginning date of the LBP is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.~~

~~*b.* Assistance is continued pending the final decision of the appeal.~~

~~*c.* The department's action is affirmed.~~

7.9(5) *When assistance continues for managed care organization health care services.*

a. Health care services may not be reduced, limited, suspended, canceled or other proposed adverse action taken pending a final decision on an appeal when:

(1) An appeal is filed timely. "Timely" means the appeal is filed on or before the effective date of the adverse benefit determination or within ten calendar days of the date the managed care organization sent the notice of adverse benefit determination. The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period;

(2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(3) The services were ordered by an authorized provider;

(4) The original period covered by the original authorization has not expired; and

(5) The appellant requests that health care services be continued.

b. If, at the appellant's request, the managed care organization continues or reinstates the member's health care services while the appeal is pending, the benefits must continue until one of the following occurs:

(1) The appellant withdraws the appeal.

(2) The appellant fails to request an appeal within ten calendar days from the date the managed care organization mails the notice of action.

(3) A hearing decision is issued that is adverse to the appellant.

~~**7.9(6)** *Recovery of assistance when a new ineligibility period is established for the use of an electronic access card at a prohibited location.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new ineligibility period is established for the use of an electronic access card at a prohibited location. A new ineligibility period pursuant to 441—subrule 41.25(11) shall be established when the department is affirmed in an appeal of the establishment of an ineligibility period for the use of an electronic access card at a prohibited location. All of the following conditions shall exist:~~

~~*a.* The appeal is filed either:~~

~~(1) Before the effective date of the intended action on the notice of decision or notice of action establishing the beginning date of the ineligibility period, or~~

~~(2) Within ten days from the date on which a notice establishing the beginning date of the ineligibility period is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.~~

~~*b.* Assistance is continued pending the final decision of the appeal.~~

~~*c.* The department's action is affirmed.~~

7.9(6) *When assistance does not continue for health care services managed by a managed care organization.* Health care services may be reduced, limited, suspended, canceled or other proposed adverse action taken pending a final decision on an appeal when:

a. An appeal is not filed timely. "Timely" means the appeal is filed on or before the effective date of the adverse benefit determination or within ten calendar days of the date the managed care organization sent the notice of adverse benefit determination. The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period;

b. The appeal does not involve the termination, suspension, or reduction of a previously authorized course of treatment;

c. The services were not ordered by an authorized provider;

d. The original period covered by the original authorization has expired; or

e. The appellant fails to request that health care services be continued.

7.9(7) *Recovery of excess assistance paid pending a final decision on appeal.* Continued assistance is subject to recovery by the department if the department's action is affirmed, except as specified at subrule 7.9(9).

When the department's action is sustained, excess assistance paid pending a final decision shall be recovered to the date of the decision. This recovery is not an appealable issue. However, appeals may be heard on the computation of excess assistance paid pending a final decision.

7.9(8) *Recovery of excess assistance paid when the appellant's benefits are changed prior to a final decision.* Recovery of excess assistance paid will be made to the date of change which affects the improper payment. The recovery shall be made when the appellant's benefits are changed due to one of the following reasons:

a. A determination is made at the hearing that the sole issue is one of state or federal law or policy or change in state or federal law or policy and not one of incorrect grant computation, and the grant is adjusted.

b. A change affecting the appellant's grant occurs while the final decision is pending and the appellant fails to request a hearing after notice of the change.

7.9(9) *Recovery of assistance when a new limited benefit plan is established.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new limited benefit plan period is established. A new limited benefit plan period shall be established when the department is affirmed in a timely appeal of the establishment of the limited benefit plan. All of the following conditions shall exist:

a. The appeal is filed either:

(1) Before the effective date of the intended action on the notice of decision or notice of action establishing the beginning date of the limited benefit plan, or

(2) Within ten days from the date on which a notice establishing the beginning date of the limited benefit plan is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. Assistance is continued pending the final decision of the appeal.

c. The department's action is affirmed.

7.9(10) *Recovery of assistance when a new ineligibility period is established for the use of an electronic access card at a prohibited location.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new ineligibility period is established for the use of an electronic access card at a prohibited location. A new ineligibility period pursuant to 441—paragraph 41.25(11)*"e"* shall be established when the department is affirmed in an appeal of the establishment of an ineligibility period for the use of an electronic access card at a prohibited location. All of the following conditions shall exist:

a. The appeal is filed either:

(1) Before the effective date of the intended action on the notice of decision or notice of action establishing the beginning date of the ineligibility period, or

(2) Within ten days from the date on which a notice establishing the beginning date of the ineligibility period is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. Assistance is continued pending the final decision of the appeal.

c. The department's action is affirmed.

ITEM 20. Amend rule 441—7.10(17A) as follows:

441—7.10(17A) Procedural considerations.

7.10(1) *Registration.* Upon receipt of the notice of appeal, the ~~department~~ appeals section shall register the appeal.

7.10(2) *Acknowledgment.*

a. Upon receipt of the notice of appeal, the ~~department~~ appeals section shall send an acknowledgment of receipt of the appeal to the appellant, representative, or both. A copy of the acknowledgment of receipt of appeal will be sent to the appropriate departmental office.

b. and *c.* No change.

7.10(3) *Granting a hearing.* The ~~department~~ appeals section shall determine whether an appellant may be granted a hearing and the issues to be discussed at that hearing in accordance with the applicable rules, state statutes, or federal regulations.

a. The appeals of those appellants who are granted a hearing shall be certified to the department of inspections and appeals for the hearing to be conducted. The ~~department~~ appeals section shall indicate at the time of certification the issues to be discussed at that hearing.

b. The appeals of those appellants who are denied a hearing shall not be closed until issuance of a letter to the appellant and the appellant's representative, advising of the denial of hearing and the basis upon which that denial is made. Any appellant that disagrees with a denial of hearing may present additional information relative to the reason for denial and request reconsideration by the ~~department~~ appeals section or a hearing over the denial.

7.10(4) *Hearing scheduled.* For those records certified for hearing, the department of inspections and appeals shall establish the date, time, method and place of the hearing, with due regard for the convenience of the appellant as set forth in 481—Chapter 10 of the department of inspections and ~~appeals~~ appeals' rules ~~481—Chapter 10~~ unless otherwise designated by federal or state statute or regulation.

a. No change.

b. In cases of appeals by ~~vendors or~~ agencies, the hearing shall be scheduled by teleconference call or at the most appropriate department office.

c. No change.

d. In cases involving an appeal of a sex offender risk assessment, the hearing or administrative review shall be held within 30 days of the date of the appeal request.

e. No change.

f. In cases involving appellants who indicate that their lives, physical or mental health, or ability to attain, maintain or regain maximum function could seriously be jeopardized if they wait for standard resolution of their appeals, the hearing shall be held within three working days of the date on the appeal request if:

(1) The managed care organization handled the first-level review expeditiously; and

(2) The appellant or a provider acting on the appellant's behalf requested an expedited appeal hearing.

7.10(5) *Method of hearing.* The department of inspections and appeals shall determine whether the appeal hearing is to be conducted in person, by videoconference or by teleconference call. The parties to the appeal may participate from multiple sites for videoconference or teleconference hearings. Any appellant is entitled to an in-person hearing if the appellant requests one. Upon advance request, a witness shall be permitted to appear by teleconference unless the administrative law judge determines that the physical presence of the witness is necessary for the administration of justice and does not impose an undue burden on the witness. All parties shall be granted the same rights during a teleconference hearing as specified in rule 441—7.13(17A). The appellant may request to have a presiding officer render a decision for attribution appeals through an administrative hearing.

7.10(6) *Reschedule requests.* Requests by the appellant or the department to set another date, time, method or place of hearing shall be made to the department of inspections and appeals directly except as otherwise noted. The granting of the requests will be at the discretion of the department of inspections and appeals.

a. The appellant may request that the teleconference hearing be rescheduled as an in-person hearing. All requests made to the ~~department~~ appeals section or to the department of inspections and appeals for a teleconference hearing to be rescheduled as an in-person hearing shall be granted. Any appellant request for an in-person hearing made to the ~~department~~ appeals section shall be communicated to the department of inspections and appeals immediately.

b. ~~All other requests concerning the scheduling of a hearing shall be made to the department of inspections and appeals directly.~~ For food assistance appeals, the hearing may be rescheduled if requested by the appellant; however, the postponement shall not exceed 30 days.

c. For intentional program violation appeals, the hearing may be rescheduled provided that the request for postponement is made at least ten days in advance of the date of the scheduled hearing. The hearing shall not be postponed for more than a total of 30 days.

d. Reschedule requests made by the department shall only be granted in instances of inclement weather when the department office is closed. The department's representative shall arrange coverage by a coworker in instances including, but not limited to, when inclement weather is present, but the department office remains open or when a family emergency, sudden illness or death occurs.

e. All other requests, subject to paragraph 7.10(6)*"a,"* concerning the scheduling of a hearing shall be made to the department of inspections and appeals directly.

7.10(7) *Notification.* For those appeals certified for hearing, the department of inspections and appeals shall send a notice to the appellant at least ten calendar days in advance of the hearing date.

a. and *b.* No change.

c. Notices of hearing regarding an intentional program violation shall be served upon the appellant ~~both by certified mail, return receipt requested, and~~ by first-class mail, postage prepaid, addressed to the appellant at the last-known address at least 30 days in advance of the date the hearing is scheduled. All other notices of hearing shall be mailed by first-class mail, postage prepaid, addressed to the appellant at the appellant's last-known address.

ITEM 21. Amend paragraph **7.13(5)"b"** as follows:

b. A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party's failure to appear or participate at the contested case proceeding ~~and~~. A party must ~~be filed~~ file the motion with the Department of Human Services, Appeals Section, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. The department or its representative shall file a motion to vacate as specified in subrule 7.16(6). Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact. Each affidavit must be attached to the motion. In lieu of submitting an affidavit, the moving party may submit business records or other acceptable documentation from a disinterested third party that substantiates the claim of good cause.

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the ~~department~~ appeals section to respond to the motion to vacate. All parties to the appeal shall be allowed to conduct discovery as to the issue of good cause and shall be allowed to present evidence on the issue before a decision on the motion, if a request to do so is included in that party's response. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the ~~department~~ appeals section.

(2) No change.

ITEM 22. Amend paragraph **7.13(5)"f"** as follows:

f. ~~Upon a final decision granting a motion to vacate~~ Once the time limit to appeal a proposed decision has expired, the contested case hearing shall proceed accordingly, after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.

ITEM 23. Amend paragraph **7.13(6)"c"** as follows:

c. A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party's failure to appear or participate at the contested case proceeding ~~and~~. A party must ~~be filed~~ file a motion with the Department of Human Services, Appeals Section, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the ~~department~~ appeals section to respond to the motion to vacate. All parties to the appeal shall be allowed to conduct discovery as to the issue of good cause and shall be allowed to present evidence on the issue before a decision on the motion, if a request to do so is included in that party's response. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the ~~department~~ appeals section.

(2) No change.

ITEM 24. Amend paragraph **7.13(6)"g"** as follows:

g. ~~Upon a final decision granting a motion to vacate~~ Once the time limit to appeal a proposed decision has expired, a new contested case hearing shall be held after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.

ITEM 25. Amend subrule 7.16(4), introductory paragraph, as follows:

7.16(4) *Appeal of the proposed decision.* After issuing a proposed decision, the administrative law judge shall submit it to the ~~department~~ appeals section with copies to the appeals advisory committee.

ITEM 26. Amend paragraph **7.16(9)"a"** as follows:

a. A final decision on the appeal shall be issued within the following time frames:

(1) Appeals for all programs, except food assistance ~~and vendors~~, shall be rendered within 90 days from the date of the appeal.

(2) and (3) No change.

ITEM 27. Amend rule 441—7.19(17A) as follows:

441—7.19(17A) Accessibility of hearing decisions. Summary reports of all hearing decisions shall be made available to local offices and the public upon request. The information shall be presented in a manner consistent with requirements for safeguarding personal information concerning applicants and recipients.

ITEM 28. Amend subrule 7.21(1) as follows:

7.21(1) *Appeal hearings.* All appeal hearings in the food assistance program shall be conducted in accordance with ~~federal regulation, Title 7, Section~~ 7 CFR 273.15~~, as amended to January 1, 2008~~.

ITEM 29. Amend subrule 7.21(2) as follows:

7.21(2) *Food assistance administrative disqualification hearings.* All food assistance administrative disqualification hearings shall be conducted in accordance with ~~federal regulation, Title 7, Section~~ 7 CFR 273.16~~, as amended to January 1, 2008~~.

ITEM 30. Amend subrule 7.24(1), introductory paragraph, as follows:

7.24(1) *Necessary emergency action.* To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the United States Constitution and the Iowa Constitution and other provisions of law, the department of inspections and appeals may issue a written order in compliance with Iowa Code section 17A.18 to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the ~~department~~ agency by emergency adjudicative order. Before issuing an emergency adjudicative order, the department of inspections and appeals shall consider factors including, but not limited to, the following:

ITEM 31. Amend subrule 7.42(3) as follows:

7.42(3) The day after the department's decision on reconsideration is issued is the first day of the period in which the appeal may be filed. The mailing address is: Department of Human Services, Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Appeals may also be sent by fax, e-mail, or in-person delivery.

When an appeal is submitted through an electronic delivery method, such as electronic mail or facsimile, the appeal is filed on the date it is submitted. The electronic delivery method shall record the date and time the appeal request was submitted. If there is no date recorded by the electronic delivery method or the appeal was filed via in-person delivery, the date of filing is the date the appeal is stamped received by the agency. Receipt date of all appeals shall be documented by the office where the appeal is received.

When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

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